DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10008

Registration District No. 4 — Primary Registration District No. 3001 — Registrar's No. 66

1. PLACE OF DEATH:

(a) County: Adair

(b) City or town: Kirksville
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: ✓
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: ✓ (Specify whether)
In this community: 20 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Adair

(c) City or town: Kirksville
(If outside city or town limits, write "RURAL")

(d) Street No.: 412 N. New St.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? ---
years.

3. (a) PRINT FULL NAME: Trella Willard

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Female

5. Color or race: White

6. (a) Single, widowed, married, divorced: Divorced

6. (b) Name of husband or wife: Ralph Willard

6. (c) Age of husband or wife if alive: 49 years

7. Birth date of deceased: April (Month) 30 (Day) 1893 (Year)

8. AGE:

Years	Months	Days	If less than one day
46	10	18	hr. min.

9. Birthplace: Macon County (City, town, or county) Mo. (State or foreign country)

10. Usual occupation: Shop-Keeper

11. Industry or business: Kodak and Camera Shop

MOTHER FATHER

12. Name: W. L. Emmons

13. Birthplace: Macon County (City, town, or county) Mo. (State or foreign country)

14. Maiden name: Nancy McCarty

15. Birthplace: Macon County (City, town, or county) Mo. (State or foreign country)

16. (a) Informant's own signature: Trella Willard

(b) Address: Kirksville, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-20-1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Highland Park

18. (a) Signature of funeral director: Davis Funeral Home

(b) Address: Kirksville, Mo.

19. (a) 3-19-40 (Date received local registrar) (b) Spencer L. Freeman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 17
year 1940 hour 8 minute 20 P.M.

21. I hereby certify that I attended the deceased from March 17, 1940, to March 17, 1940, that I last saw h[illegible] alive on March 17, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Coronary Thrombosis	4 hours
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations:

Of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature: John K Denby (M.D. or other) Address: Kirksville Date signed 3/14/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

50M-5-17-39
Rev. 5-17-39
I X19311

9416

RECEIVED
District Health Officer No. 10
District File Number 4-40-860
Date Filed APR 16 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by....., Registered Apprentice No....., working under my personal supervision.

Signed Harold H. Wigal

Licensed Embalmer No. 4076

P. O. Address Kirksville, M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
—2-21-40
I X12659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STANDARD CERTIFICATE OF DEATH

State File No. 10008

Registration District No. 4 — Primary Registration District No. 3001 — Registrar's No. 66

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Trella Willard
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced Wid
6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years
7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 46 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 17
year 1940 hour minute M.
21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Coronary Thrombosis	2 hrs
Due to Chronic Myocarditis	
Due to	
Other conditions (Include pregnancy within 3 months of death) No puerperal condition	
Major findings: Of operations 42 C	
Of autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Joshua H. Denby (M. D. or other)
Address Kirksville Date signed

SUPPLEMENTARY

S-10008